

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155689		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 06/24/2014	
NAME OF PROVIDER OR SUPPLIER COURTYARD HEALTHCARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2400 COLLEGE AVE GOSHEN, IN 46526			
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F000000	<p>This visit was for Recertification and State Licensure Survey.</p> <p>Survey Dates: June 17, 18, 19, 20, 23 and 24, 2014</p> <p>Facility Number: 000091 Provider Number: 155689 Aim Number: 100290080</p> <p>Survey Team: Sharon Ewing, RN TC Lora Swanson, RN (June 17, 18, 19, 23 and 24) Deb Kammeyer, RN Julie Wagoner, RN</p> <p>Census bed type: SNF: 37 SNF/NF: 120 Total: 157</p> <p>Census payor type: Medicare: 17 Medicaid: 101 Other: 39 Total: 157</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>			F000000	<p>Please accept this Plan of Correction as our facility's Credible Allegation of Compliance for our Recertification and State Licensure Survey concluded on June 24, 2014.</p> <p>Submission of this Plan of Correction is not an admission by Courtyard Healthcare Center that the deficiencies alleged in the survey are accurate or that they depict the quality of nursing care and services provided to the residents of our facility. This Plan of Correction is being submitted solely because doing so is required by State and Federal law.</p> <p>Considering the volume, scope, and severity of the alleged deficient practices noted in the CMS-2567, Courtyard Healthcare Center respectfully requests a desk review for this survey. If approved, we would be willing to provide any and all documentation requested including, but not limited to: education records, policies and procedures, checklists, and forms that have been completed, revised, or implemented as a part of this Plan of Correction.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2014
FORM APPROVED
OMB NO. 0938-0391

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F000159 SS=B	<p>Quality Review completed on June 30, 2014, by Brenda Meredith, R.N.</p> <p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p>						

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	<p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>Based on interview and record review, the facility failed to ensure residents had access to petty cash from resident's personal funds accounts on an ongoing basis during normal business hours. This deficient practice affected 3 of 4 residents who were reviewed for personal funds. (Resident # 16, 140 and 93)</p> <p>Findings include:</p> <p>On 6/17/14 at 2:59 P.M., an interview was conducted with Resident # 16. When asked the question "...Can you get your money when you need it, including on weekends?..." Resident # 16 indicated "...Closed on the weekend...."</p> <p>On 6/17/14 at 3:14 P.M., an interview was conducted with Resident # 140. When asked the question "...Can you get</p>		F000159	<p>F159 Facility Management of Personal Funds Facility will continue to hold, safeguard, manage, and account for the personal funds of the resident deposited within the facility, upon written authorization of a resident.</p> <p>Corrective Actions: Facility procedures have been amended to include banking hours on Saturday and Sunday in order to allow reasonable access to resident funds within the timeframe specified in F159. Residents and their families will be formally notified of this change prior to July 24, 2014. Facility policy will remain unchanged as it meets the requirements set forth in F159. How Others Identified: All residents with funds deposited with the facility have the potential to be affected by this alleged deficient practice.</p> <p>Preventative Measures: Facility staff has been trained on</p>		07/24/2014	

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	<p>your money when you need it, including on weekends?....Resident # 140 indicated "...Can't get any money on weekends...."</p> <p>On 6/18/14 at 8:40 A.M., an interview was conducted with Resident # 93. When asked the question "...Can you get your money when you need it, including on weekends?...." Resident #93 indicated "...Can't get it on the weekends...."</p> <p>On 6/20/14 at 9:55 A.M., an interview was conducted with the Business Office Manager. The Business Office Manager indicated residents may obtain money Monday thru Friday and Saturdays when she was in the facility. The Business Office Manager indicted, "I am usually here for a couple of hours on Saturday, it's not a specific time."</p> <p>On 6/20/14 at 10:20 A.M., the current policy, provided by the Business Office Manager, titled "...Deposit of Resident Funds...." was reviewed. The policy indicated "... Policy Interpretation and Implementation....d. Provide the resident access to funds of fifty (50) dollars or less within twenty-four (24) hours, and access to funds in excess of fifty (50) dollars within three banking days...."</p> <p>3.1-6(f)(1))</p>				<p>the availability and accounting of resident funds, utilizing the policies mentioned in the 2567.</p> <p>Monitoring: Residents who have funds managed by the facility will be interviewed periodically to ensure that they have access to their funds on weekends. Those with funds, including resident #16, #93, and #140, will be interviewed quarterly for the next two quarters with results and findings forwarded to the facility's QAPI Committee for follow-up. Date of Completion: July 24, 2014</p>		

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F000167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State				

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	<p>surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>Based on observation and interviews, the facility failed to ensure the survey results were easily assessable and their location easily identified. This potentially affected all residents in the facility and/or their family members.</p> <p>Finding includes:</p> <p>1. An interview was conducted with a representative from the Resident Council on 6/23/14 at 9:00 A.M. The Resident Council representative indicated she did not specifically remember where the survey results were kept. She indicated she thought by the therapy room where there were other contact numbers and resident rights posted on the bulletin board.</p> <p>On 6/23/14 at 9:47 A.M., an interview was conducted with Employee #20, who was working at the front desk in the lobby. Employee #20 indicated the survey results were in the Administrator's office but then she noticed a large white unlabeled three ring binder on the bottom shelf, just off the floor in height, of an</p>		F000167	<p>F167 Right to Survey Results</p> <p>Facility will continue to ensure the survey results are easily accessible and their location easily identified. Corrective Actions: During the survey, the binder containing the survey results was moved to the top of the coffee table on which it was stored and labeled with a sticker "ISDH Survey Results". At the time of survey, there was a poster outside the therapy gym indicating where the survey results could be found. How Others Identified: All residents looking to access the survey results have the potential to be affected by this alleged deficient practice. Preventative Measures: Facility staff has been trained on the location of the survey results. Monitoring: A checklist has been developed whereby the presence of the survey binder, in its specified location, will be checked daily for the next month, then three times a week for a month, and then weekly for four months. This checklist will be forwarded to the facility's QAPI Committee for follow up. IDR Requested as 2567 is inaccurate in noting that signage was not present</p>		07/24/2014	

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F000279 SS=D	<p>end table by a couch, in the lobby. She retrieved the folder and it did contain the survey results.</p> <p>3.1-3 (b)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interviews, the facility failed to develop a written comprehensive care plan for 1 of 3 residents reviewed for Activities of Daily Living (ADL's). (Resident #44)</p> <p>Findings include:</p> <p>On 6/23/14 at 9:47 A.M., a review of the</p>		F000279	<p>indicating the location of the survey results and facility asserts that the survey binder was accessible to residents at the time of survey. Date of Completion: July 24, 2014</p> <p>F279 Develop Comprehensive Care Plans Facility will continue to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>Corrective Actions: For resident #44, a care plan addressing ADLs (Activities of Daily Living) was developed,</p>		07/24/2014	

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	<p>clinical record for Resident #44 was conducted. The record indicated the resident was admitted to the facility on 6/27/13. The resident's diagnoses included, but were not limited to: rheumatoid arthritis, dementia, hypertension, abnormality of gait and muscle weakness.</p> <p>The admission nursing assessment, dated 6/27/13, indicated "...requires assist of two for transfers,...requires assist of one for dressing, toileting, personal hygiene and bathing...."</p> <p>The admission MDS (Minimum Data Set) assessment, completed on 8/8/13, indicated Resident #44 required extensive assistance for transfers, toileting, dressing and personal hygiene.</p> <p>The occupational therapy plan of care note, dated 2/11/14, indicated ADL (Activities of Daily Living) hygiene: moderate assist, ADL upper and lower body dressing: moderate assist, ADL grooming: minimal assist, ADL toileting: moderate assist.</p> <p>A CNA (Certified Nursing Assistant) worksheet, undated, indicated the resident required limited assistance for hygiene/grooming and required the assist of two staff members for transfers.</p>			<p>written, and implemented on 6/23/14, during the survey. That care plan was shared with and provided to the surveyors while they were on-site. How Others Identified: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Preventative Measures: All residents and their care plans will be reviewed to make sure that each resident has the appropriate care plans in place. Nurses and members of the IDT (Interdisciplinary Team) will be trained on Care Plans, their need, and the process for initiating and/or discontinuing them.</p> <p>Monitoring: D.O.N. and/or designee will monitor the Physician's Orders and the 24 hour report sheet daily for 2 weeks; then weekly for 2 weeks; then bi-weekly for 3 months; then monthly for 2 months to ensure that all appropriate diagnosis, medication, and condition changes are care planned. Any deficient practice will be addressed through staff education, in-servicing, and/or counseling and will be reviewed by facility's QAPI committee monthly for 6 months and as needed thereafter. Date Completed: July 24, 2014</p>			

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	<p>On 6/23/14 at 10:55 A.M., a review of an electronic activity care plan, indicated the Resident preferred to be with his wife during the day in his room and outdoors during nice weather. The interventions included: Encourage wife's involvement in group activities with resident, praise and encourage resident's activity involvement and provide a calendar in room. There was no mention of ADL's on this care plan.</p> <p>On 6/23/14 at 11:00 A.M., an interview with the DON (Director of Nursing) indicated, there was not an ADL care plan for this resident.</p> <p>On 6/24/14 at 11:20 A.M., review of the current policy titled "Care Planning-Interdisciplinary Team" received from the DON indicated "...1. A comprehensive care plan for each resident is developed within seven (7) days of completion of the resident assessment (MDS). 2. The care plan is based on the resident's comprehensive assessment and is developed by a Care Planning/Interdisciplinary Team...."</p> <p>3.1-35(a)</p>						

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interviews, the facility failed to ensure the hot water temperatures were safe and the resident environment was free from hazardous materials and chemicals on 2 of 3 nursing units. This potentially affected 121 of 153 residents in the facility.</p> <p>Findings include:</p> <p>1. During observations of room and resident bathrooms, conducted on 06/18/14 between 9:15 A.M. - 9:45 A.M., a razor was noted on the bathroom sink in Resident Room 116 and Resident Room 113. There was also shaving cream noted beside the razor in the bathroom of Resident room #113.</p> <p>An Environmental tour was conducted, on 06/23/14 from 1:30 P.M. - 2:15 P.M., with Employee #22, the Maintenance Supervisor and Employee #23, the Housekeeping Supervisor. The following chemicals were noted in resident bathrooms:</p>		F000323	<p>F323 Free of Accident Hazards/Supervision/Devices Facility will continue to ensure that the resident environment remains as free of accident hazards as is possible; and that each resident receives adequate supervision and assistance devices to prevent accidents. Corrective Actions: As noted in the 2567, the mixing valve problem that caused the water temperatures to be outside of the 110-120 range was corrected within minutes of the temperatures being taken. As also noted in the 2567, razors and chemicals allegedly spotted during observations were also removed during the survey. How Others Identified: All residents have the potential to be affected by this alleged deficient practice. Preventative Measures: Staff has been in-serviced on accidents & hazards, including the need to keep chemicals and razors secure as well as the procedure to report to maintenance any abnormal water temperatures and/or when residents complain of inappropriate water temperatures. Monitoring:</p>		07/24/2014	

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F000329 SS=D	<p>Room 206, there was a container of "Bathroom Cleaner Wipes" on top of the paper towel dispenser in the bathroom.</p> <p>Room 111, there was a can of "Scrubbing Bubbles" bathroom toilet cleaner in the bathroom on the sink. A warning label on can indicated: "Hazard to humans and domestic animals."</p> <p>The razors and can of shaving cream previously noted in the bathrooms for Resident room #113 and 116 had been removed. Interview with Employee #23, the housekeeping supervisor, indicated she had noted a surveyor "looking at those items" and had removed them.</p> <p>2. During the survey, conducted on 06/17/14 - 06/23/14, there were confused ambulatory and confused residents who could propel their wheelchair independently noted wandering on both the Birch and Cedars nursing unit. On two occasions confused resident were noted to go into other resident's rooms.</p> <p>3.1-45(a)(1) 3.1-19(r)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p>				<p>Executive Director (or designee) will conduct resident room rounds to ensure that chemicals and hazards, such as those noted in the 2567, are identified, removed and/or secured, and addressed with residents, families, and staff. Such rounds will be conducted weekly for one month, every-other-week for a 2nd month, and monthly for the following four months. The results of those rounds will be forwarded to the facility's QAPI Committee for follow-up and corrective action, if any. Water temperatures will continue to be checked weekly and results will be forwarded to the facility's QAPI committee for follow-up and corrective action IDR requested by facility as surveyor specifically indicated that water temperatures would not be cited. Date of Completion: July 24, 2014</p>		

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	<p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interviews, the facility failed to ensure the drug regimen of 2 of 5 residents was free from unnecessary medications, including a medication initiated for insomnia without documented issues with sleep for Resident #93 and an antipsychotic medication utilized for behaviors that had the dose increased without indications for Resident #60.</p> <p>Findings include:</p> <p>1. The clinical record for Resident #93 was reviewed on 06/19/14 at 12:58 P.M.</p>	F000329	<p>F329 Drug Regimen is Free from Unnecessary Drugs Facility will continue to ensure that each resident's drug regimen is free from unnecessary drugs. Corrective Actions: Resident #60 began a Gradual Dose Reduction (GDR) of Zyprexa on 6/27/14 as a result of the Monthly Behavior Meeting, the plan for which was told to the surveyor during the survey. Resident #93's diagnosis for Trazadone was clarified to be used for depression. Lexapro was discontinued. Elavil is used for neuropathy. Resident is receiveing Tramadol at bedtime for pain. How Others</p>		07/24/2014		

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	<p>Resident #93 was admitted to the facility on 10/15/12, with diagnoses, including but not limited to, depressive disorder, diabetes mellitus, polyneuropathy, muscle weakness, hypertension, cardiac dysrhythmia, history of chest pain, arteriosclerosis, chronic kidney disease stage 3, gout, seborrhea dermatitis, atrial fibrillation, diverticulosis of the colon, diaphragmatic hernia, and history of falls.</p> <p>The current physician's orders for medications, included an order, dated 04/23/14, for Trazadone, an antidepressant with sedating properties, 25 mg (milligrams) every day at hs (bedtime) for chronic insomnia</p> <p>Review of nursing progress notes, from April 1 - 23, 2014, indicated there was no documentation of any signs and/or symptoms of insomnia.</p> <p>Review of the Behavior Book tracking for Resident #93 indicated he was being tracked for concerns about wife and getting upset with staff. There was no tracking for insomnia.</p> <p>The care plan related to insomnia, initiated on 04/24/14, included the following interventions: "Before using any hypnotics, try another intervention to improve sleep..., encourage resident to</p>		<p>Identified: All residents receiving medications have the potential to be affected by this alleged deficient practice.</p> <p>Preventative Measures: Nursing staff and Medical Director have been in-serviced on the need to attempt non-pharmacological interventions before the initiation or increase of a pharmacological intervention. All efforts will be documented. Nursing staff has been educated and must consult with DON (or designee) prior to initiating orders for psychoactive medications. Monitoring: Interdisciplinary Team (IDT) will review and monitor Behavior Logs including interventions 5 times/week to ensure appropriate interventions were attempted and medication changes are made only when evidence of need has been documented. IDT findings will be forwarded to facility's QAPI Committee for follow-up and corrective action, if any, each month for the next six months. IDR requested as facility does not believe that this citation reflects the spirit of the regulation Date of Completion: July 24, 2014</p>				

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	<p>talk about what woke resident, evaluate other factors potentially causing insomnia, for example noise, lighting, hot/cold, caffeine/medications., offer back rub, offer warm drink, or snack...."</p> <p>Interview with the Social Service Director for the Cedars unit, Employee #24, on 06/24/14 at 9:45 A.M., indicated the resident had complained of insomnia to his physician and the physician had put the resident on the Trazadone to help with insomnia. Review of a physician's progress note, dated 02/13/14, indicated the physician had documented the resident had issues with sleep due to worrying about his wife. The subsequent physician's visit note, dated 04/10/14, documented no issues with insomnia, depression, or anxiety.</p> <p>Review of the Behavior/Psychotropic Meds: Quarterly Review notes, dated 06/03/14, indicated the resident was receiving antidepressant medications for behaviors and depression only. The note indicated both Trazadone and Elavil were being given for insomnia and diabetic neuropathy. The form indicated "trouble with sleep onset" was to have been tracked and current interventions were appropriate.</p> <p>Other than a physician's progress note in</p>						

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	<p>February 2014, there was no documentation of insomnia issues for Resident #93, nor was there any documentation non-homological interventions were attempted and causative factors assessed prior to initiating an antidepressant medication for sleep issues.</p> <p>2. The clinical record for Resident #60 was reviewed on 06/20/14 at 10:57 A.M. Resident #60 was admitted to the facility on 08/22/08, and readmitted to the facility on 10/10/12, with diagnoses, including but not limited to, episodic mood disorder, vascular dementia with depressed mood, impulse control disorder, gastroparesis, epilepsy, major depression, depressive psychosis, personality disorder, anxiety state, cerebrovascular accident, dysphagia, neurogenic bladder, hypertension, diabetes, cataract, hyperlipidemia, esophageal reflux, edema, constipation, and generalized pain.</p> <p>The current physician's orders for medications, included the following antipsychotic medications: Zyprexa 5 mg bid (twice daily) for episodic mood disorder and Abilify 10 mg bid for depressive disorder.</p> <p>Review of the physician's discontinued</p>						

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	<p>orders and interview with the Unit Manager , LPN #21, on 06/24/14 at 10:00 A.M., indicated the facility had reduced the resident's Zyprexa from a total of 5 mg a day to 2.5 mg a day on January 22, 2014. The resident was discharged to an acute care facility due to a medical change in condition and returned to the facility on 05/07/14, with order for Zyprexa a total of 10 mg a day. The Unit Manager indicated she thought they had contacted the resident's medical physician regarding the increase in the Zyprexa and she (the Medical Director) wanted to leave the medications alone until the next Behavior meeting. However the unit manager confided that was because the medical physician did not manage the resident's psychiatric medications. She indicated the resident was "seen by psych." There were no psychiatric notes after the resident's acute care center admission. There was also no documentation the psychiatrist had been notified of the quadrupled dose of Zyprexa ordered upon the resident's readmission to the facility from the Acute care center.</p> <p>In addition, there was a quarterly Behavior/Psychotropic Meds meeting regarding Resident #60's medications conducted on 06/03/14. The resident's Zyprexa dose was documented on the</p>						

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F000431 SS=D	<p>form but there was no documentation indicating there had been an increase in the dose, no documentation supporting the increased dose, and no documentation indicating the psychiatrist or physician had been notified of the increased dose.</p> <p>There had been no behavior issues documented for June 2014 for Resident #60.</p> <p>Also, there was a social service note, dated 05/08/14, which indicated the resident had returned from a local hospital on 05/07/14, and there had been no changes in the antipsychotics, antidepressants or anxiety medications.</p> <p>3.1-48(a)(6)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate</p>						

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	<p>reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview the facility failed to ensure expired medication was removed from 3 of 9 medication carts reviewed for medication storage, this resulted in 2 of 3 resident's receiving expired medication, (Resident #194, Resident #38 and Resident #104)</p> <p>Findings include:</p>	F000431	<p>F431 Drug Records, Label/Store & Biologicals</p> <p>Corrective Actions: The three vials of insulin have been disposed of and both residents who received the insulin noted have been assessed and found to have no ill effects from its use.</p> <p>How Others Identified: All residents receiving insulin have the potential to be affected by this alleged deficient practice.</p> <p>Preventative Measures:</p>	07/24/2014			

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	<p>On 6-20-14 9:05 A.M., a medication cart was observed for expired medications with LPN#15. A vial of novolog (insulin) for Resident #194, had an open date of 5-19-14. The unit director indicated the medication should have been removed as expiration date for opened novolog is 28 days after date of opening; therefore the medication expired on 6-16-14. A review of the electronic MAR (medication administration record) indicated the resident had received 3 doses (2 units three times a day with meals by subcutaneous injection) of insulin from the expired vial on 6-17-14, 3 doses on 6-18-14, 3 doses on 6-19-14 and 1 dose on 6-20-14.</p> <p>On 6-20-14 at 10:58 A.M., during an observation of the medication cart, on the Dogwood Unit with LPN #16, a vial of novolog for Resident #38 had an opened date of 5-22-14 and expired on 5-19-14. The electronic MAR indicated the resident had received a dose of insulin (3 units) on 6-20-14 at 7:00 A.M., from the expired vial of novolog.</p> <p>On 6-20-14 at 11:38 A.M., a medication cart was observed for expired insulin, with LPN #17. The cart contained an open vial of Novolog for Resident #104. The vial was opened on 5-22-14 and was expired on 6-19-14. The electronic MAR</p>			<p>Nurses have been re-trained on procedures relating to insulin—affixing of “date opened” and “expiration” stickers, doing routine med cart checks to look for expired medications, and the proper method of disposal of said medications if and when they are found. Facility has implemented a nightly audit of med carts, including checking for expiration dates, OTC labels, date opened stickers, and loose medications. Nurses and/or Unit Managers will complete the audits 5 times/week for the next six months Monitoring: Upon doing the med cart checks, Unit Managers (or designee if UM is unavailable) will complete a checklist indicating that all insulin-related procedures are in place—“date opened”, “expiration”, etc. The results of these audits will be forwarded to the facility’s QAPI Committee for follow up for the next six months.</p> <p>Date Completed: July 24, 2014</p>			

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	<p>indicated the resident had not received a dose of the expired medication due to her blood sugar and sliding scale results prior to breakfast.</p> <p>On 6-20-14 at 1:16 P.M., a policy titled "Administering Medications" revised April 2007 indicated "... 7. Check the expiration date on the medication label..."</p> <p>On 6-20-14 at 1:45 P.M., a form provided by the DON (Director of Nursing) titled "Pharmacy Audit Assistance Service" indicated a humalog 10 milliliter vial expires 28 days after opening.</p> <p>During an interview on 6-23-14 at 1:57 P.M., the DON indicated her expectation would be, "a nurse should dispose of an expired vial."</p> <p>3.1-25(o)</p>						
F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable</p>						

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	<p>environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to ensure linens were disposed of appropriately in an isolation room for 1 of 1 residents observed with a Clostridium difficile (C. difficile) infection (Resident #154) and oxygen and catheter tubing was</p>	F000441	<p>F441 Infection Control, Prevent Spread, Linens Facility will continue to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of</p>		07/24/2014		

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	<p>positioned properly for 1 of 14 residents in the facility with indwelling Foley catheters (Resident #181).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #154, reviewed on 06/24/14 at 11:30 A.M., indicated the resident was diagnosed with a positive Chlostridium difficile infection on 06/10/14.</p> <p>Resident #154 was observed, on 06/19/14 at 2:26 P.M., in her room lying in her bed. She indicated her dialysis treatment was scheduled for tomorrow. She indicated she was having issues with diarrhea and gas. She complained about being too crowded in her present room. She further indicated the facility had moved her from another unit to her current room due to an infection. The room was noted to be very crowded with her and her roommates personal items and two red isolation barrels. The resident's dirty laundry was observed to be piled in an open small laundry basket, with a pair of underwear on the top. In addition, there was a large zippered tote bag and a clear plastic bag with a dark colored cloth item in it, noted wedged between the two red barrels. An interview with Resident #154 indicated the zippered tote was the bag she took to</p>				<p>disease and infection.</p> <p>Corrective Actions: Facility staff has been in-serviced on Policy and Procedure related to "Contact Precautions", in general, and Clostridium Difcil, in particular. Facility's policy on "Contact Isolation" has been amended to include instructions regarding the handling of soiled and/or potentially contaminated linens. Resident #181 had a privacy bag and a drainage bag with one-way valve to prevent backflow or urine to his urinary tract at the time of survey. Resident has a Care Plan in place regarding him pulling his drainage bag out of the privacy bag multiple times daily while moving around in his room. Resident was placed on frequent checks so that staff may re-place the drainage bag into the privacy bag and remove the tubing from the floor. How Others Identified: All residents have the potential to be affected by this alleged deficient practice.</p> <p>Preventative Measures: Nursing and laundry staff has been in-serviced on isolation procedures including the handling of soiled linen. Nursing staff has been in-serviced regarding privacy bags and catheter tubing placement. Monitoring: D.O.N. (or designee) will conduct Infection Control Rounds on all residents requiring isolation precautions 5 times/week for 30 days; 3 times/week for 60 days;</p>		

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	<p>her dialysis treatments and the clear plastic bag contained one of her personal blankets. She was not sure if the blanket was clean or soiled. She did not know why the blanket and tote were lying placed between the isolation barrels. She and her roommate, Resident # 16 indicated often times items and other soiled linens and trash were piled on top of the isolation barrels because no one would empty them timely. She thought perhaps when they emptied the trash from the isolation barrels, the tote and blanket might have fallen between the barrels.</p> <p>Resident #154 was observed in the hallway, dressed, in her wheelchair, on 06/20/14 at 10:00 A.M. The resident indicated she was going to be leaving soon for her dialysis treatment. The resident's room was observed and there was a bedspread noted piled on top of one of the red isolation barrels in her room. There were two isolation barrels noted in her room. The laundry basket full of laundry noted yesterday was not in her room. A nurse entered the room at 10:11 A.M. and placed the bedspread, which had been piled on top of one of the isolation barrels, and some linens from the resident's roommates bed in a clear plastic trash bag and transported it to the soiled laundry room.</p>				<p>and once/week for 90 days. DON (or designee) will conduct Infection Control Rounds on residents with catheters to ensure privacy bags and tubing are placed appropriately 5 times/week for 30 days; 3 times/week for 60 days; and once/week for 90 days Results of the Infection Control Rounds will be forwarded to the facility's QAPI Committee for the next six months. Date Completed: July 24, 2014</p>		

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	<p>The facility policy, provided by the Director of Nursing, on 06/24/14, titled "Clostridium Difficile," dated April 2007, indicated affected residents who are symptomatic required "Contact Isolation." There was no specific instructions regarding the disposal of soiled and/or possibly contaminated linens.</p> <p>2. On 6-19-14 at 1:02 P.M., Resident #181 was observed in bed with his Foley catheter bag and tubing lying on the floor. The bag and tubing had cloudy, yellow urine in them. In addition, the resident's oxygen tubing and nasal canula was observed on the floor next to the concentrator.</p> <p>On 6-20-14 at 7:33 A.M., Resident #181 was observed in bed lying on his right side, his Foley catheter bag and tubing was lying on the floor.</p> <p>On 6-20-14 at 11:26 A.M., Resident #181 was observed in bed lying on his back, his Foley catheter bag was lying on the floor.</p> <p>On 6-23-14 at 11:10 A.M., the Director of Nursing provided a policy titled "Emptying a Urinary Drainage Bag," dated 2005, and indicated the policy was</p>						

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F000465 SS=E	<p>the one currently used by the facility. The policy indicated "...9. Keep the drainage bag and tubing off the floor at all times to prevent contamination and damage...."</p> <p>On 6-23-14 at 2:35 P.M., Resident #181 was observed in bed lying on his back, his Foley catheter bag was lying on the floor.</p> <p>3.1-18(b)(2)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure bathrooms and walls in Resident rooms on the Cedar and Birch units were in good repair and were clean and free from odors. This affected residents in Rooms 205, 219, 216, and 130.</p> <p>Finding includes:</p> <p>During the Environmental tour, conducted on 06/23/14 from 1:30 P.M. - 2:15 P.M. with Employee #22, the Maintenance supervisor and Employee #23, the Housekeeping supervisor, the following was noted:</p>			F000465	<p>F465 Safe/Functional/Sanitary/Comf ortable Environment The facility will continue to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Corrective Actions: The resident room and bathroom walls noted in the 2567 (those in rooms #130, #205, #209, & #216) have been repaired. The walls in rooms #130 & #219 have been cleaned. The rusted toilet riser in room #130 has been replaced. Room #205 has been vacated until the odor noted in the 2567 can be resolved How Others Identified: All residents have the potential to be affected by this</p>		07/24/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>In Room 205 , there was a strong urine odor still apparent in room. Employee #23 indicated she had been trying to "take care" of the odor issue.</p> <p>In Room 219, the walls were scuffed just above rim of trash can with the underlying wallboard exposed and it was also scuffed on the wall entering the bathroom, in a 6 inch linear fashion. There was also dried splattered, white substance on the wall around and above a small trash can in the room. The splatters had been noted the previous week from 06/18/19 - 06/20/14.</p> <p>In Room 216, there was scrape with exposed wallboard on the wall behind the head of bed #1. The area was approximately a 2 x 4 inch rectangle in size.</p> <p>In Room 130, there was a gouge behind the head of bed.#1. The gouge was indented, the size of a baseball, with the dry wall noted on the floor underneath area In addition, there was a brown smear noted on the trash can in bathroom The brown smear had previously been noted on 06/19/14 and had not been cleaned. There was also a rusted area on the toilet riser on the front of the seat.</p>			<p>alleged deficient practice. Preventative Measures: Executive Director (or designee) will be initiating environmental rounds on a more formal schedule. Said rounds will be completed weekly for the 1st four weeks, with all rooms having been assessed during that time frame. Rounds will continue on a monthly basis thereafter. Rounds will assess and document any and all areas needing repair, replacement, and areas needing to be cleaned. Monitoring: The results of the environmental rounds will be forwarded to facility's QAPI Committee for follow-up and resolution. Date of Completion: July 24, 2014</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	3.1-19(f)						